Rev. 7/98

CERTIFICATION OF HEALTH CARE PROVIDER
***(FAMILY AND MEDICAL LEAVE ACT OF 1993*)**
Please call 316-268-4531, if you have questions regarding this form.
Fax 316-268-4286

1. EMPLOYEE'S NAME _____

2. PATIENT'S NAME _____
***(If different than employee*)**

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category or categories:

(1)__ (2)__ (3)__ (4)__ (5)__ (6)__, or other _____

4. Describe the medical facts which support your certification, including a brief statement of how the medical facts meet the criteria of one of these categories:

5. a. State the approximate beginning date of the condition and its probable duration._____
Also state the probable duration of the present incapacity if different from the condition date._____

b. Will it be necessary for the employee to work only intermittently or to work less than a full schedule as a result of this condition? Include treatment described in Item 6 below.

Intermittent _____ Yes _____ No _____ Reduced Schedule _____ Yes _____ No

If yes, for either, give probable duration:_____

c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity**?

6. a. If additional treatments will be required for this condition, provide an estimate of the probable number of such treatments._____

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any:

b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), state the nature of the treatments:

c. If a regimen of continuing treatment is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment.):

* Throughout this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

**Incapacity, for FMLA purposes, is defined as the inability to work, attend school or perform other regular daily activities due to a serious health condition, treatment for, or recovery from.

7. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

_____

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? (The employee or the employer should supply you with information about the essential job functions) _____ Yes _____ No

If yes, please list the essential functions the employee is unable to perform:

c. If neither a nor b applies, is it necessary for the employee to be absent from work for treatment?
_____ Yes _____ No

8. a. If leave is required to care for the employee's family member with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?
_____ Yes _____ No

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?
_____ Yes _____ No

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____ _____ _____
Signature of Health Care Provider Date Type of Practice

_____ _____
Street address Telephone number

_____
City, State and Zip

==========

TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER

==========

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

_____ _____
Employee signature Date

==========

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care - Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment (a) A period of incapacity** of more than three consecutive calendar days (including any subsequent treatment or period of incapacity** relating to the same condition) that also involves:

   (1) Treatment*** two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

   (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment**** under the supervision of the health care provider.

3. Pregnancy - Any period of incapacity of due to pregnancy, or for prenatal care.

4. Chronic Condition Requiring Treatment - A chronic condition which:

   (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider.

   (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   (3) May cause episodic rather than a continuing period of incapacity* (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term Conditions Requiring Supervision - A period of incapacity** which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples are Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions) - Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under the orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity** of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

==========

**Incapacity, for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

***Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

****A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

APPLICATION FOR FAMILY AND/OR MEDICAL LEAVE

(READ THE BACK PAGE BEFORE COMPLETING THE APPLICATION)

Application Date _____ Social Security# _____

Name _____ Job Title _____

Department _____ Division _____ Work Phone _____ Immediate Supervisor _____

Home Address _____ Home Phone _____

Street City Zip Code

Do you have a spouse employed by the City?

☐ No

☐ Yes - Name _____ Department _____

Reason for Leave Request:

Child Care (non-health related) ☐ Birth ☐ Adoption ☐ Foster Care (State Approved)

Serious Health Condition ☐ Self ☐ Spouse ☐ Parent ☐ Child

Explanation of Leave Request:

(If medical, Certification of Physician or Practitioner form, justifying need for leave ***must*** be attached.)

Leave Duration:

☐ Continuous from _____ through _____ Total number of weeks _____

☐ Intermittent from _____ through _____ Total number of weeks _____

☐ Reduced Schedule _____ through _____ Total number of weeks _____

Physician's Name _____ Office Phone _____

Use of Sick Leave - (Choose One):

See #4 on reverse side

☐ Use all paid leave before using unpaid leave

☐ Retain a minimum of 80 hours sick leave - (Applies only if leave is for a qualifying family member)

If you want to avoid discontinuing City health insurance, indicate how you want to pay your share of the premium If you will go into unpaid status during your leave

☐ *Prepayment by payroll deduction*

☐ *Prepayment by personal check - (Overpayments will be refunded)*

☐ *Payment by personal check* ☐ biweekly ☐ monthly

Indicate whether or not any of the following programs are to be continued:

➔ Checking YES to continue any benefit requires that arrangements be made with Personnel to pay those amount that would have been payroll deducted, plus the balance of the life insurance premium.

➔ Checking NO to discontinue any benefit may require completion of a form which can be obtained from Personnel.

Yes	No		Yes	No	
☐	☐	Health Insurance	☐	☐	Flexible Spending
☐	☐	Dental Insurance	☐	☐	Friendship Fund
☐	☐	Life Insurance	☐	☐	Union Dues
☐	☐	Voluntary AD &D			

Acknowledged by Department Director _____ Date

FAMILY & MEDICAL LEAVE GUIDELINES

1. The Family and Medical Leave Act (FMLA) allows up to 12 weeks of unpaid (or combination or unpaid and paid) leave for an employee's own serious medical condition, or that of a parent, spouse or child; or for the birth, adoption or foster care placement of a child.

2. Eligibility: Employees who have worked for the City for at least 12 months (consecutively or nonconsecutive), and have been in pay status for at least 1250 hours during the previous 12 months.

3. "Child": a biological, adopted, or state approved foster child, stepchild, or legal ward; under 18 or disabled.

4. Use of Leave: (1) If FMLA leave is used for an employee's own medical condition, he/she must use all accrued paid leave before taking unpaid leave. (2) If FMLA leave is used for a qualifying family member, the employee must use all paid leave before taking unpaid leave, except for the option to retain 80 hours of Sick Leave. (3) If FML is used for birth, adoption or foster care placement, all accrued paid Vacation Leave must be used before using unpaid leave. In case of birth, the mother may use her accrued paid Sick Leave. The father may use Immediate Family Sick Leave as specified in the Personnel Manual. Also, for adoption or foster care placement, Immediate Family Sick Leave may be used.

5. To Apply: Complete the Application and the Certification of Need forms, both available in Personnel. The Certification must be submitted within 15 calendar days of application for FML if leave is for employee's own serious health condition or a qualifying family member's.

6. Leave Schedules: FML may be taken consecutively, intermittently (disconnected periods of less than 12 weeks), or on a reduced schedule (some leave being taken, such as each week, on a regular basis).

7. If both a husband and wife are City employees, up to 12 weeks of FML may be shared by both for the birth or placement of a child, or to care for parents (not in-laws). The limitation does not apply to FML taken by either spouse to care for the other, for his or her own illness, or to care for a child.

8. Benefits: Employees on FML will continue membership in the same retirement plan, but neither employee nor City contributions will be made during unpaid FML, nor will additional service credit accrue.

   Employees on unpaid FMLA leave must pay both the employee and City shares of life insurance premiums. The City will continue its share of health insurance premiums, but the employee must still pay his/her share to continue insurance,

   Any employee program involving payroll deductions may be continued while on FMLA leave, but the employee must arrange with Personnel (either before the leave begins, or during the first week) to make the payments directly. Any program will cease if a payment is not made. If an employee does not return to work from unpaid leave (for reason other than a continued serious health condition), he/she will be liable for health insurance premiums paid by the City during the FMLA leave.

   Call Personnel (268-4531) with questions about Family and Medical Leave. Fax 316-268-4286.